

EPIDEMIOLOGICAL STUDIES ON MENTAL HEALTH NEEDS OF
ASIAN POPULATION IN NEW ZEALAND

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ABSTRACT

Background: New Zealand has recently experienced a massive and rapid influx of Asian migrants. The Asian population has doubled in 10 years and is now the third-largest ethnic group.

Materials: Databases reviewed include Medline, NZ government reports and NZ media releases.

Discussion: Despite the significant growth in the Asian population, most of whom are in a vulnerable age group for mental morbidity and are exposed to adverse experiences, accurate and systematically obtained information on the mental health of Asians is lacking.

Conclusion: This paper argues for a need to conduct a well-designed epidemiological study on the mental health needs of Asians in New Zealand. Recommendations on how to pursue this epidemiological study are provided.

INTRODUCTION

The world has seen massive movements of populations from one continent to another over past two centuries, making migration a global phenomenon. Shifting involves losses and disruption to familiar life patterns as well as exposure to new experiences and challenges. Relocated people are exposed to stress and may experience mental health problems (Abbott, 1997). Despite the global scale of migration and its impact on mental health, the shortage of well-designed studies on the topic is surprising. This paper argues for conducting an epidemiological study on mental health needs of Asians in New Zealand. In this context we refer to (a) three largest subgroups of Asians (Chinese (44%), Indian (26%) and Korean (8%)) and (b) those experiencing the fastest rate of growth in recent years (overseas-born Chinese, Indians, Koreans and Japanese) (Statistics New Zealand, 2002).

**ASIAN MIGRATION IN NEW ZEALAND: TRENDS AND IMPACT ON
MENTAL HEALTH**

New Zealand experienced a sudden increase in the number and ethnic diversity of migrants only from the late 1970s (Abbott, 1997). Prior to that the country had two main ethnic groups, 'Pakeha' (White European settlers) and 'Maori' (indigenous people in New Zealand).

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Changes were made in migration legislation in 1987 and 1991 to remove a bias in favour of British and West Europeans, who were considered 'preferred sources' of migrant population in New Zealand (Brooking & Rabel, 1995). From 1997 to 2001 the Asian population increased by 140% over a 10-year period (1991–2001) (Statistics New Zealand, 2002). This growth has created unique opportunities for investigating the relationship between migration and mental health – for a variety of reasons.

First, migration of Asians has occurred at a rapid rate. A twofold increase in the Asian population occurred between 1991 and 2001 – the Asian ethnic group comprised 6.6% (or 272,000 Asians) of the usually resident population at 30 June 2001 compared with 3% in 1991 (Statistics New Zealand, 2003). Compared with the UK and USA, where such migration has happened over several decades (Office of Population Censuses and Surveys, 1991; Anathanarayanan, 1994; Abbott, 1997), New Zealand's experience has been so rapid that it has not allowed time for acclimatisation to the host population or the health care system. The US Department of Housing and Urban Development argues that a population growth rate of 10% per year for a small community begins to strain the local service delivery systems including health. Above 15% these systems begin to break down (Guillaume & Hayes, 1980). The growth of the Asian population in New Zealand averages 14% a year. It is hardly surprising that a recent report acknowledged that the mental health needs of Asian immigrants were not being adequately met in the country (Ho *et al.*, 2002). Studies from other countries have focused on service utilisation rates (Abbott, 1997) and community- or hospital-based prevalence of psychiatric disorders or psychological problems in Asian migrants in comparison with the native population (Cochrane, 1979; Cochrane & Stopes-Roe, 1981; Gupta, 1991). Population-based studies of psychological morbidity in first-generation migrants are largely lacking globally. In the context of Asians in New Zealand we are in a unique position where we can investigate the effects of migration on the mental health of the first-generation migrants arriving in a country that is still culturally very different to their own.

Second, there may be an opportunity to examine the effects of migration on the host society. New Zealand has had a bicultural society and with Asian immigrants this may change. A treaty signed between the Maori and the British Crown (the Treaty of Waitangi) in 1840 has formed the foundation of New Zealand society by identifying only two ethnic groups but not excluding either. The emphasis on biculturalism has made New Zealand distinctive among the four 'traditional lands of immigration' in North America and Australasia (Canada, USA, Australia and New Zealand) (Fleras, 1998). Among the four, New Zealand's indigenous population has played a prominent role in debates about the development of social, health and economic policy. With the influx of Asian migrants, pressure may mount in New Zealand to formalise multiculturalism as a counterweight to biculturalism for working through differences in a changing and increasingly diverse society (Fleras, 1998). It is worth embarking on research on how society adjusts to change of this significance.

Third, the Asian population in New Zealand is largely young and growing. In 2001, 21% of the Asian population was in the 15–24 year age group, compared with 14% of the total New Zealand population (Statistics New Zealand, 2002). This is especially relevant given that serious mental illness tends to occur in early adulthood. The young age profile of the Asian communities will reach the 'at risk' age over the next few years. It is important that epidemiological study of Asian migrants' mental health issues is conducted now, particularly

because the combination of vulnerable age group and adverse life experiences associated with migration may disproportionately increase the risk of mental morbidity. Existing evidence, both from New Zealand and overseas, indicates that Asian immigrants experiencing acculturation problems also report greater mental morbidity (Cheung & Spears, 1995a, 1995b; Pernice *et al.*, 2000; Patel & Gaw, 1996; APHPT, 2003). A literature review concluded that the suicide rate of young Indian immigrant women globally was consistently higher than their male counterparts and women of their host countries and yet mental illness was rarely cited as a cause. (Patel & Gaw, 1996).

EPIDEMIOLOGICAL STUDY IS A NECESSITY NOT A LUXURY

We have established that the population of Asians in New Zealand is growing and that mental health issues, although under-recognised, could be significant. We argue that epidemiological studies and not health service utilisation studies should be conducted in New Zealand.

Asian migrants have a different or delayed pattern of seeking help (Sue *et al.*, 1991), have a lesser probability of being referred to specialist services by their GPs (Chung *et al.*, 2003) and face barriers because of language difficulties, reliance on family resources, failure to detect psychiatric symptoms and reluctance in seeking help from primary care workers (McDonald & Steel, 1997). Epidemiological studies conducted now will yield accurate information for the National Mental Health Strategy currently in development. However, effective implementation of the strategy requires accurate information, which is lacking in psychiatric morbidity among Asians. Three recent reports have stated that a lack of coordination of various social and health services across government and non-government sectors is a major problem in addressing Asian mental health needs (Ho *et al.*, 2002; Asian Public Health Project Team, 2003; Yee, 2003). An epidemiological study will not only gather population-based evidence on the priority areas of mental health needs, but will also inform about the migration trends, and help health planners make projections for future developments.

Asians in New Zealand are a very heterogeneous group culturally and linguistically. This will make the task of combining data collected from diverse ethnic groups and drawing conclusions about rates of disorders, level of severity, use of services and associated risk and protective factors challenging. There may also be striking similarities within Asians which may include post-immigration adjustment to a new culture, social isolation, experiences of being discriminated against and employment (Jones, 2000). Socially or self-assigned ethnicity may be preferred for data collection because of the ongoing debate on what constitutes race as opposed to ethnicity (Singh, 1997). Priority will need to be given to the main Asian sub-groups in New Zealand, with focus on first-generation immigrants and apparent high-risk groups (e.g. international Asian students, older people, women, members from small Asian communities).

CONCLUSIONS

New Zealand can be perceived as an unusual country for Asians to migrate to because of its bicultural identity. Biculturalism can pose added stress to a 'visible minority' group. Evidence

from some small studies has showed increased rates of psychiatric morbidity in specific Asian groups in New Zealand. A true picture of the mental health of Asians in New Zealand can only be obtained through a culturally appropriate and sensitive epidemiological study and is badly needed. Results from a well-designed epidemiological study can influence mental health policy and service delivery for the third-largest ethnic group in New Zealand and may provide information that has not been available before in the history of global migration.

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